Health Home Orientation

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Orientation Outline

- Introduction to Health Homes
- Health Home Infrastructure
- Who Health Homes will serve
- Health Home Core Services
- Health Home Quality Methodology and Measures
- Lessons learned in other states
- Management Tools
- Information Sharing
- Recipient issues
- Resources
- Summary

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Introduction to Health Homes

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What is a Health Home?

- Created by Section 2703 of the ACA to help reduce the cost of services for some High Cost High Risk Medicaid populations.
- Health Homes are a systematic and comprehensive approach to the delivery of primary care or behavioral health care that promises better patient experience and better results than traditional care.
- This approach is designed to affect change in a Health Home recipient's health status and to reduce utilization of high cost services.
- Six Core Services outlines by CMS and defined by the Health Home Workgroup must be provided to each Health Home recipient.

What makes a successful Health Home?

- **Integration** of clinical care, support services, internal and external resources.
- **Coordination** of all care, including prevention, primary care, specialty care, behavioral health, hospitalization and transitions.
- **Communication** vertically and horizontally – within the Health Home, with the recipient and family members, with others involved in the care process.
- **Access** to health coaches, designated providers, the right clinical setting, and
- **Education** for the recipient and family, the Health Home, clinical and social support referral sources.

Six Core Services

- Six Core Services must be provided:
    1. Comprehensive care management
    2. Care coordination
    3. Health promotion
    4. Comprehensive transitional care/follow-up
    5. Patient and family support
    6. Referral to community and social support services

Not the same as patient centered Medical Home

Category	Health Homes	Medical Homes
Populations Served	Individuals with specified chronic conditions; Medicaid population	All populations served
Staffing	Includes a designated provider with A support team of health professionals and social services. Both primary care and behavioral health health homes.	Are typically defined as physician-led primary care practices, but also mid-level practitioners
Payers	Currently are a Medicaid-only construct	In existence for multiple payers: Medicaid, commercial insurance, etc.
Care Focus	Strong focus on integrating behavioral health (including substance abuse treatment), social support, and other services (including nutrition, home health, coordinating activities, etc.)	Focused on the delivery of traditional medical care: referral and lab tracking, guideline adherence, electronic prescribing, provider-patient communication, etc.
Technology	Use of IT for coordination across continuum of care, including in-home solutions such as remote monitoring in patient homes	Use of IT for traditional care delivery

Source: Smith, Alicia.(2011, June 7). Overview of Medicaid health home care coordination benefit. National Council Webinar

What must a Health Home do?

- Provide quality driven, cost effective, culturally appropriate person/family-centered services.
- Coordinate/provide access to high quality, evidence based services, preventive /health promotion services, mental health/substance abuse services, comprehensive care management/coordination/transitional care across settings, disease management, individual/family supports, Long Term Care supports and services.
- Develop a person-centered care plan that coordinates/integrates clinical/non-clinical health care needs/services.
- Link services with health information technology, communicate across team(s), individual and family caregivers, and provide feedback to practices, and
- Establish a continuous quality improvement plan.

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Health Home Infrastructure

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Health Home Infrastructure

- Two types of Health Homes – PCP and Community Mental Health Centers (CMHC)
  - Designated providers for Health Homes include providers licensed by the State of South Dakota who practice as a primary care physician, (e.g., family practice, internal medicine, pediatrician or OB/GYN), physicians assistant, an advanced practice nurse practitioner working in a Federally Qualified Health Center, Rural Health Clinic, or clinic group practice; or a mental health professional working in a Community Mental Health Center.
  - Each designated provider attests that they meet the provider standards.
  - The designated provider leads a team of health professionals needed to support each recipient. The team may include a primary care physician, physician assistant, advance practice nurse, behavioral health provider, a health coach/care coordinator/care manager, chiropractor, pharmacist, support staff, and other services as appropriate and available.

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Who do Health Homes serve?

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Who do Health Homes serve?

- Medicaid recipients who have…
  - Two or more chronic conditions OR one chronic and at risk for another (Defined separately):
    - **Chronic conditions include:** Mental illness, substance abuse, asthma, COPD, diabetes, heart disease, hypertension, obesity, musculoskeletal, and neck and back disorders.
    - **At risk conditions include:** Pre-diabetes, tobacco use, cancer, hypercholesterolemia, depression, and use of multiple medications (6 or more classes of drugs).
  - One severe mental illness or emotional disturbance.
- Eligibility based on 15 months of claims data based on diagnosis.
- Medicaid recipients that meet criteria are stratified into four tiers based on the recipient's illness severity using CDPS (Chronic Illness and Disability Payment System).

What is CDPS?

- Publicly available tool validated for use in Medicaid populations, developed by the University of California San Diego.
- Used by States who use Medicaid Managed Care Companies to manage their populations including Washington, Utah, Delaware and Michigan.
- Accounts for broad spectrum of diseases (not just those included in HH definition) and historical costs in order to predict risk for future high costs.
- CDPS stratifies each diagnostic category into hierarchical levels of severity that demonstrate the level of healthcare needs of a recipient with a diagnosis within a given category.
- Analytics/tier assignment best performed at state/third-party level.

Review Flowcharts

- Attribution Flowchart
- Health Home Services Flowchart

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Core Services

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Six Core Services

- CMS requires the six Core Services be provided to all enrolled recipients.
- Health Homes are paid a monthly PMPM for the delivery of the Core Services. All medical services continue to be reimbursed according to the current reimbursement structure.
- Health Home minimum requirement is to provide one of the Core Services to each recipient every quarter and to have this action recorded in the Electronic Health Record. Recipient should be engaged by the action – not simply provider care conference.
- Health Home can determine method to be used to report this information on a quarterly basis. Information to DSS should include Recipient ID, Name and a Y/N indicating if a Core Service has been provided.

1. Comprehensive Care Management

- Comprehensive Care Management is the **development** of an individualized care plan with active participation from the recipient and health home team members.

- Each recipient's individual care plan is based on a comprehensive assessment with all identified issues incorporated into the care plan and documented in the EHR.

- The designated provider is responsible for providing for all of the recipient's health care needs. Takes responsibility for:
  - Arranging care as needed
  - Coordination with other qualified professionals
  - Discussing appropriate access to care (ER utilization)
  - Preventive education
  - Conducting a standard behavioral health assessment of your choosing.

- Provides same day appointments, timely clinical advice by telephone during and after office hours (24/7), and documents clinical advice in the medical record.

Key Elements of a Care Plan

- Care Plans are an integral part of serving recipients in Health Homes.
- Each clinic or Health System is allowed to choose a template for their Care Plan, but a Care Plan must be completed on each recipient in Health Homes..
- Care Plans should:
  - Include basic information about the recipient;
  - Summarize the recipient's medical conditions and medications;
  - Identify those involved (providers, family, other services);
  - Summarize recipient's social situation (housing, employment, transportation etc.);
  - Summarize recipient's barriers;
  - Establish goals to improve health and overcome barriers.
- If behavioral health needs are identified in the assessment, Care Plan should include plan to address.
- Care Plans should be developed with active participation from the recipient and natural supports of their choosing.

2. Care Coordination

- Care coordination is the **implementation** of the individualized care plan that coordinates appropriate linkages, referrals, and follow-up to needed services and supports.
- The Health Home care coordinator or Health Home team is responsible for the management of the recipient's overall care plan.
- Shares key clinic information (problem list, medication list, allergies, diagnostic test results) with other providers involved in the care of recipients.
- Integration of medical or behavioral health expertise is crucial to serve the whole person. For example, the Health Home team of a recipient with a severe mental illness who has co morbid physical conditions should include a physician or advanced practice professional as part of the team and vice versa.
- DSS nurses will conduct a random sample of case reviews to ensure care coordination is being provided.

3. Health Promotion

- Health promotion services **encourage and support** healthy ideas and concepts to motivate recipients to adopt healthy behaviors and enable recipients to self manage their health.

- The Health Home care coordinator will provide health promotion activities. Specific activities may include, but are not limited to the following:
  - Provide health education to recipients and their family members specific to the recipient's chronic conditions and/or behavioral health conditions;
  - Develop disease specific self-management plans;
  - Provide education regarding the importance of immunizations and screenings, child physical and emotional development; and
  - Promote healthy lifestyle interventions for substance use and prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity.

4. Comprehensive Transitional Care

- Comprehensive transitional care services are a **process** to connect the designated provider team and the recipient to needed services available in the community.

- Health Home has the overall responsibility and accountability for coordinating all aspects of transitional care including transitions to home, long term care, rehab and other settings.

- Each Health Home recipient will receive a card on the bottom of the letter that confirms they are part of a Health Home and who is serving as their designated provider. Health Homes need to teach recipients the importance of sharing their Health Home card along with their Medicaid card with each provider. Additionally, they need to ask the provider to notify designated provider that they were admitted to a facility.

4. Comprehensive Transitional Care Continued

- Health Home must have agreements or a method in place to receive notification when a recipient is admitted to the hospital or seen in an ER within 24 hours as well as any transitions that may be occurring to ensure that they receive information from other systems when a person is transitioning from one care setting to another or to home. The Health Home must also contact the recipient within the first 48 hours after the transition occurs. This will allow the Health Home to:
  - Facilitate interdisciplinary collaboration during transitions;
  - Provide comprehensive transitional care activities, including, whenever possible, participating in discharge planning; and
  - Collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing the recipient's and family members' ability to manage care and live safely in the community.

5. Recipient and family support services

- Recipient and family **support services** reduce barriers to recipient's care coordination, increase skills and engagement and improve health outcomes.
- A defined member of the designated provider care team is responsible for engaging and educating the recipient/family about implementing the care plan using methods that are educationally and culturally appropriate.
- Assess barriers to care and working with the recipient/family to overcome barriers such as medication adherence, transportation and keeping appointments.
- Identify resources for recipients to support them in attaining their highest level of health and functionality in their families and in the community.
- Provide information on advance directives in order to allow recipients/families to make informed decisions.

6. Referrals to community & social support services

- Referrals to community and social **support services** provide recipients with referrals to support services to help overcome access or service barriers, increase self management skills and improve overall health.
- Responsible for identifying available community-based resources and manage appropriate referrals.
- Coordinates or provide access to recovery services and social health services available in the community (may include housing, personal need and legal services).
- Provide assistance to obtain and maintain eligibility for health care, disability benefits, etc.
- Support effective collaboration with community based resources.

Health Home Referral Process

- Health Home recipients will be required to obtain a referral prior to seeing a provider other than their designated provider.
- Health Home Referral Cards will be provided to each Health Home. Health Homes should implement a process for obtaining resulting medical records, test results and/or procedure summaries when providing a referral.
- Referral flowchart

Management tools provided by DSS

- Each Health Home will receive data to help them manage their caseload.
  - Caseload Reports – will list all recipients attributed to the Health Home.
    - Will be sent in paper format at the beginning of each month.
    - It is important to monitor these reports month to month to see who has dropped off of your caseload as a result of losing eligibility for Medicaid or who has selected another provider.
    - It is also important to check eligibility for Medicaid at the first visit.
  - Claims data – at the end of each month, claims data for each recipient will be loaded by clinic to a Secure FTP site. Clinic will need to use the provided username and password to view or download. Format provided on the web at http://dss.sd.gov/healthhome/outcomemeasures.asp.
- DSS plans to convene Health Home providers on a quarterly basis to facilitate discussion on successes, challenges, and lessons learned. Information gathered will help ensure continuous quality improvement and may lead to changes in the design of Health Homes.

Information Sharing about Health Home Recipients

- **Key federal and state regulations governing the release of behavioral health protected health Information (PHI)**
  - Federal law, specifically the Health Insurance Portability and Accountability Act (HIPAA), outlines the requirements for protection and disclosure of PHI. This information can be found in federal regulations 45 CFR Parts 160 and 164 and federal regulation 42 CFR Part 2 for Alcohol and Drug Abuse protected health information.
- **Physical and behavioral health providers can share a patient's behavioral health PHI**
  - If the patient has been notified of the potential release of this specific PHI and to whom. Proper authorizations to release PHI must contain specific references to behavioral health PHI. The client should be informed, at the time of authorization, that this specific PHI will be released to whom and for what purposes.
  - Providers should use the "minimum necessary rule" under HIPAA, to determine what behavioral health PHI should be shared. Providers must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request".

Lessons Learned from other States

- Clinics in other states where health homes have been implemented have found it to be challenging to ensure that **notification** happens in a timely fashion after an admission to facilities.
  - Clinic should have the necessary conversations with other Health Systems or independent facilities to ensure that notification is made within 24 hours.
- Integration between physical and behavioral health has also proven to be a challenge
  - Perform a standard assessment on every recipient to determine what if any behavioral health services are needed.
  - Make sure that your team includes (internal or external) someone who can deal with the behavioral health components if a PCP, or the physical health components if a CMHC. This integration is critical to the success of the program.
- Other states who have implemented Health Homes have indicated that Health Homes err on the side of caution when sharing information about recipients. Sharing information is an important component of a successful health home.
  - Make sure to have recipients sign an agreement that allows you to share information including behavioral health PHI. The agreement should include sharing data with the State, other providers and or support service agencies.

More Lessons Learned from other States

- Health Homes in other states have found that recipient social status is important to the outcomes of Health Homes.
  - Health Homes should continuously review the recipient's housing, legal and employment status to help determine what social support services are needed by the recipient.
- Health Homes in other states have found it important not to reinvent the wheel.
  - Where possible leverage existing processes and initiatives currently being conducted in your facility i.e. Medical Home initiatives. Health Homes, however, must note the differences and be sure to comply with the Health Homes requirements.
  - Use the Health Homes requirements as an impetus to improve relationships and communications in areas where you may not have previously succeeded.
    - Physical and Behavioral Health Integration
    - Notifications from other facilities.
- Other states have found it useful to participate in learning forums.
  - Participate in the sharing opportunities that DSS provides on a quarterly basis.

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Outcome Measure Requirements

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Health Home Outcome Measures

- Health Homes require specific measures in the area of Clinical Outcomes, Experience of Care, and Quality of Care.
- Quality Plan has three goals with appropriate measures for PCP HH and CMHC HH
  - Minimum of one clinical indicator for each disease category
  - Patient and family experience/satisfaction measure
  - Cost and effectiveness measures
- Each Health Home will submit data electronically at the individual level every 6 months.
- Outcome measures and data file layouts are posted on the web at http://dss.sd.gov/healthhome/outcomemeasures.asp.

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How to Handle Recipient Issues

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How to handle difficult recipient issues

- Goal is to experience minimal recipient issues, however if over time there are significant issues with a recipient, a disenrollment process has been established.
- Review disenrollment process.

DSS Resources for Health Homes and Recipients

- Website http://dss.sd.gov//healthhome/index.asp.
- Health Home Brochure (Will be sent to all health home recipients with first letters.)
- Recipient Handbook (New version for July 2013 with Health Home information. Will be posted on the web at http://dss.sd.gov/formspubs/ Handbook will be under the documents for Medical Services.
- Access to DSS Health Home team
  - (605) 773-3495
  - Medical@state.sd.us. Use Health Homes in the title

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What makes a Health Home successful?

Integrate clinical care with the support services available to the recipient. Coordinate all care provided by the team. Communicate within the health home and with the recipients and their families. Provide access to the care team in the right clinical setting. Educate the recipient and family on the clinical and social aspects of their health plan.

Summary

Through the provision of the 6 core services, the Health Home initiative aims to reduce inpatient hospitalization and emergency room visits, increase the integration between physical and behavioral health services, and enhance transitional care between institutions and the community.

Success requires a systematic and comprehensive approach to the delivery of primary care and behavioral health care that promises a better patient experience and better results than traditional care.

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Questions and Thank You!

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